

Clinical Implications of Research on Brief Dynamic Psychotherapy

II. How the Therapist Helps or Hinders Therapeutic Progress

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In this second of a two-part article, we describe how the therapist's interpretations promote therapeutic progress. Any therapist behavior that is in accord with the patient's plan will be helpful to the patient, but interventions that are at cross purposes with the patient's plan will not be helpful. The implications of the plan concept for brief dynamic therapy are described and contrasted with other key technical concepts such as transference interpretations, therapeutic alliance, and interpretive activity. The importance of understanding the patient's plan and intervening in accord with it are illustrated in several case vignettes.

We would like to begin this paper by reporting an experience one of us (G.S.) had in graduate school. Before starting my training in New York, I worked at Mount Zion Hospital for a psychologist who was actively involved in the work of Sampson and Weiss and the Mount Zion Psychotherapy Research Group. After my second year of graduate school, I came back to San Francisco and talked with my friend about theories of therapy and how therapists help or hinder patients' progress. The advice that my friend left me with was this: "To do good therapy, you need to figure out basically what the patient wants and how you can help the patient get it." In other words, it is essential to determine what the patient's plan for therapy is. When I returned to

New York, my fellow students were eager to hear what wisdom had come from the West Coast, and I told them about the need to figure out what the patient's plan is. The initial reaction to this point of view was at best anticlimactic. They said that it seemed too simplistic: Where is the notion of ambivalence; the complexity of impulse-defense configurations; the layers of defenses, and so on? Well, I started supervision with a fairly traditional psychoanalyst, and we discussed a woman whom I saw in twice-a-week, insight-oriented therapy. He formulated the case in terms of Oedipal dynamics, which seemed accurate for this patient. After working with this supervisor for several months, I told him about the work of the Sampson-Weiss group (Weiss, Sampson, & The Mount Zion Psychotherapy Research Group, in press), and suggested looking at the case from the point of view of what the patient wants, where the patient is trying to go, and how I am helping or not helping her to get there. He too thought that this was a rather narrow, overly simplified perspective, and added: "Besides, what your patient wants most fundamentally is a penis. And unless you think you can help her get it, I can't see how this approach would be very useful."

What this experience drove home was the importance of distinguishing between the patient's id impulses and our concept of patient plans, which we covered in the preceding paper. What we will discuss now is how a patient's plan can serve to guide therapy. We start with a very broad generalization: A therapist helps the patient primarily by intervening in a way that facilitates the patient's plan — by behaving in a manner that the patient will experience as plan-compatible. Only those interventions that are in accord with the patient's plan will be helpful; all other interventions will either be noise in the system or else they will be unhelpful.

Although the focus of this paper is not on our research, we just want to say in passing that in the brief therapies we have studied we have observed that those cases in which the majority of therapist interventions were plan-compatible tended to have the best outcomes. Similarly, those cases in which the majority of interventions were incompatible with the patient's plan tended to have rather poor outcomes. If this pattern holds up over a large number of cases, it will represent strong empirical support for the plan concept.

IMPLICATIONS FOR BRIEF THERAPY

What is the relevance of the plan concept for brief psychotherapy? First of all, as Dr. Hildebrand mentioned in his article, because the therapy is brief, it is very useful early in the treatment to have a clear formulation of what the patient is up to and what the patient wants. Dr. Hildebrand noted that at the Tavistock Clinic, they generally like to have a good idea of where the therapy

is going to go after the first session because they only have 14 hours left. So the plan concept, from that point of view, has a great deal of practical relevance to brief therapy (although we would say equally so for longer-term therapy). Second, perhaps more important, is the notion that plan compatibility challenges many of the general recommendations for specialized techniques that are often touted in the brief therapy literature: for instance, the importance of actively interpreting the transference and of confronting resistance, and the need for the therapist to establish a quick therapeutic alliance, to maintain a focus, to be active, and to focus consistently on termination. The plan concept, and in particular, the emphasis on interventions that are in accord with the patient's plan is much more specific and much more precise than any of these generic recommendations. From the plan point of view, these broad technical recommendations are at the wrong level of abstraction, and as a result they really have very little relevance to working with any particular patient. For example, Malan (1963, 1976) and others (Marziali, 1984) have shown that patients who receive frequent transference interpretations tend to have positive therapy outcomes. However, transference interpretations are not universally helpful. A patient who grew up with an overly involved and intrusive parent could be hindered by a therapist who made frequent transference interpretations; the therapist's behavior would be experienced as intrusive by the patient, and could thus closely parallel the way in which the patient had been traumatized as a child. For this kind of patient, a focus on transference could be quite detrimental.

A similar point can be made regarding the therapeutic alliance, which is an important concept nowadays for brief therapy, as well as for longer-term therapies. One frequently cited manifestation of a good therapeutic alliance is the patient's positive attitude toward the therapist and toward the treatment process. However, certain patients can be overly positive toward the treatment as part of an effort to restore the therapist. One of the cases that we studied rather closely, for example, was a case where the therapist made interpretations that were consistently off the mark and frequently incorrect. The patient was trying to extricate herself from a very poor marriage, and the therapist consistently focused on what he perceived to be the patient's wishes to remain in the marriage, on her fear of abandonment, on her dependency needs, and so on. This line of interpretation was clearly at cross purposes to the patient's plan, and yet the patient often responded overtly in a glowingly positive way toward the therapist. An intensive study of the case revealed that the patient's positive responses represented an unconscious compliance with the therapist; she viewed the therapist as weak and insecure, and her exaggerated positive responses represented an effort to restore the therapist. Even though the patient showed no improvement (in fact, there was evidence of deterioration), she was rated (on a standard therapeutic alliance scale) as manifesting a positive therapeutic alliance. The alliance concept can be equally

misleading in patients who manifest extremely negative, critical views of the therapist. Such negative patient attitudes are generally interpreted as representing a poor therapeutic alliance. However, we have seen a number of cases where patients behaved in an extremely negative, hostile, or critical manner and yet made incredible therapeutic progress, suggesting that they were working quite adaptively and progressively with the therapist. We give a more detailed example of such a case later in this paper.

Another recommendation frequently encountered in the literature is that therapists need to be much more active in brief therapy than they do in longer-term therapies. Like the concepts of therapeutic alliance and transference interpretation, there are problems with a broad prescription for greater levels of therapist activity in brief treatments. There are certainly patients who do well with active therapists. For example, a patient that we studied in our sample grew up in a family where there was a tremendous amount of denial and very little parental involvement. This patient did exceptionally well with a therapist who was active and confrontational because the patient experienced the therapist as involved, realistic, and strong—qualities which the patient's parents clearly lacked. On the other hand, there were a number of patients treated by this same active therapist who experienced the therapist's activity as intrusive. So again, the general recommendation to be more active is not a clinically useful one. From our point of view, what is most pertinent to helping patients in therapy is that therapists understand the patient's plan and intervene accordingly.

THE PATIENT'S TESTING OF THE THERAPIST

We will now discuss how, from our point of view, patients work in therapy and then discuss how the therapist can facilitate the patient's work. According to the Sampson-Weiss model (Weiss et al., in press), patients work in therapy through a process of testing the therapist. The patient's testing, which is largely unconscious, may take the form of transference reenactments or what Weiss refers to as transference tests (Weiss, in press). In this mode of working, patients try to assess whether a therapist will behave in the same manner as the patient's parents had behaved in childhood; that is, the patient tries to assess whether he or she will be traumatized in therapy (by the therapist) in the same way that the patient was traumatized as a child by others. For example, a patient whose parents could not tolerate the patient's autonomy and separation, might test the therapist to see whether the therapist can tolerate such behavior on the part of the patient. The patient might test the therapist in a variety of either overt or subtle ways—for example, by missing sessions in order to see whether the therapist is bothered; or by having very independent ideas, working independently of the therapist, or inde-

pendently coming up with interpretations in order to see if the therapist can tolerate being excluded in a way that the patient's parents could not. Similarly, a patient whose parents were extremely seductive in childhood might test the therapist to see if the therapist can be seduced or if the therapist will be seductive.

We will give an example from a brief (16-session) therapy case that we studied, which illustrates the importance of the therapist passing tests by intervening in a plan compatible manner — that is, in accord with the patient's plan. This particular case was chosen because it also illustrates some of the problems with broad prescriptions for technique which we discussed earlier. The patient, Myra, is a 29-year-old single woman. Her plan for therapy was to overcome a strong, unconscious pathogenic identification and compliance with her mother. Myra complied with her mother's expectations — for example, to care for and defer to others, including her mother — because she saw her mother as extremely isolated, vulnerable, and needy. She was worried that defying her mother would upset her and would be experienced by her mother as desertion. In other words, the patient was ruled by separation guilt. She was so guilty toward, and worried about, her mother that she was unable to separate from her. Similarly, Myra identified with her mother as a victim. The mother had been divorced and left by her husband in a rather unfortunate way, and the patient similarly saw herself as victimized by men. The patient thus identified with her mother because she felt guilty about allowing herself more than her embittered, unhappy mother. When she came to therapy, Myra had been involved with an alcoholic man who was much older than she. This relationship was by all counts an unsatisfying, masochistic relationship for her, and ending it was one of the main reasons why Myra sought treatment.

Before describing a particular session from the Myra case, it should be noted that all of the therapists in our study are very experienced, psychodynamically trained psychologists and psychiatrists who have had specialized training in brief as well as longer-term therapies. Each therapy session is audio-recorded, and we work from the verbatim transcripts of the case after the therapy has been completed. Thus, the therapists do not know our understanding of the patient's plan, and they conduct the therapies as they would normally carry them out. Only after the therapies are completed do we apply our concepts to determine how well they explain the therapeutic process. Myra's therapist, like all of the therapists in our study, knew nothing about our hypotheses regarding this case or our formulation of her unconscious plan.

The primary transference test in this case had to do with whether the therapist needed the patient to be unhappy, clingy, sexless, and embittered, as her mother had needed her to be. The patient inferred that when she was unhappy, involved in unfortunate relationships that were not gratifying, and so

on, her mother was most gratified. She thus had to test to see if the therapist also needed her to be in these kinds of relationships. The session to be described is hour 11. The patient had broken off the relationship with her alcoholic boyfriend, Paul, just prior to this hour. In this session, she talked about Paul and the fact that he would now like to join her in the remainder of this therapy because he cannot think of spending his life with anyone but her. She went on to say that, like Paul, she was also uninterested in pursuing other relationships and had not been dating. The therapist made the following interpretation:

It's hard to know how interested you really are in others until you've gotten away from him [Paul], and that's been very hard for you to carry through. There is a parallel between the emotional tie you have with Paul, who has difficulty establishing relationships with others, and the emotional tie that your mother has to you. Your deep feelings of obligation and guilt toward others make it hard to find something more rewarding for yourself.

In terms of the case formulation just described, this interpretation is very clearly facilitative of the patient's plan—that is, the intervention is clearly plan-compatible. Indeed, a group of four experienced clinical judges (who rated all of the therapist interpretations) rated this intervention as one of the most plan compatible in the entire therapy.

The patient had a very favorable reaction to this interpretation. Immediately after the interpretation, she became more insightful, showed more positive affect, and generally became more productive. She also began to express positive feelings about the treatment, saying that therapy had been extremely useful for her and that she felt a sense of collaboration with the therapist. In that same session, the therapist intervened in the following way: "Now that you've let yourself recognize that this relationship (meaning the therapy) has been valuable, you must have some feeling about our only having five sessions left."

The following interchange then occurred:

Patient: I'm not in touch with that feeling.

Therapist: We know you are in touch with feelings, but about this subject you are having trouble, hmm? [And then they go on arguing about this for about 5 min.]

Therapist: We've gone below the surface here in the therapy, and in an uncustomary manner for you, you've allowed that to happen, and suddenly we're going to have to pull out of that. It reminds me of what went on between you and Leon [a former boyfriend], where you felt him opening up, and you wanted to be sure it had a stop to it. And here in a way I'm doing to you what you did to Leon [i.e., stopping the therapy].

Patient: I think of it differently, because I didn't want a relationship with him, but he did.

Therapist: But I think you do want a relationship, and to open up in a relationship with me and then have it curtailed is a very painful and frustrating experience for you.

In terms of the plan formulation for this patient, these interventions are directly contrary to the earlier interventions from the same session, and they were given a very low rating on the plan compatibility scale. Rather than focusing on her separation guilt, as he had done in previous interpretations, the therapist emphasized Myra's dependency longings and her wishes to remain in this relationship with him. The patient had a negative reaction to the therapist's interpretation — her associations became constricted, she felt tense, and no new material emerged. Unfortunately, the therapist pursued this line of interpretation throughout the remainder of the therapy. The patient had a rather poor outcome; and from our point of view, one of the important contributing factors was the incompatibility of many of the therapist's interpretations with the patient's plan.

This case illustrates how some of the broad, technical recommendations for brief therapy can misguide the clinician. In the second half of hour 11 (and in many of the remaining sessions), the therapist's stance was in accord with the techniques advocated for brief treatment: He confronted the patient, he was active, he maintained the focus on termination, and he actively interpreted transference and resistance. However, his stance was not in accord with the patient's plan; he frequently failed the patient's tests, and consequently the treatment was not particularly helpful.

The second case that we will describe, Mike, is in many respects an atypical one. The patient did not meet the usual suitability criteria for brief therapy (e.g., focal conflicts, recent onset of symptoms, and a high degree of motivation), and the therapist did not follow the stance frequently prescribed for brief treatment (e.g., actively maintaining a clear and consistent focus, and actively interpreting transference and resistance). In fact, two clinicians who were not members of our research group read the case, described the therapist as distressingly inactive, and were mystified as to why the patient seemed to be improving. Nonetheless, from our point of view, the therapist's behavior was appropriate in terms of the patient's plan for therapy. Another interesting feature of this case is that the patient did not manifest what is usually taken as evidence of a therapeutic alliance. He was usually critical of the therapy, expressed doubts that it could help and that the therapist understood his problems, and was frequently extremely discouraged. From our point of view, these negative attitudes and behaviors expressed by the patient were a part of the patient's unconscious plan for overcoming his difficulties. Thus, what seemed like a negative therapeutic relationship by the usual criteria was rated by our judges as highly productive and progressive. These points will become more clear in the material which follows.

The patient was a 25-year-old, single college graduate who sought therapy because he felt unable to experience emotions strongly—"be they happiness, affection, or whatever." He had few interpersonal relationships, and these were unsatisfying to him. He had a lifelong problem with sexual impotence and was distressed about recurring sexual fantasies of being tied down or of tying a woman down. He was dissatisfied with his work; although he was a college graduate with a year of graduate work, he felt hopelessly stuck in a low-level job. Overall, he felt depressed, uninterested in anything, lonely, directionless, and in doubt whether it was worthwhile to go on living. He doubted that therapy could actually help him. Diagnostically he could be described as a depressive character disorder.

The patient was the third of four children born in a small midwestern city to very strict Roman Catholic parents. His father had remained in a low-level job throughout his career. Moreover, the father had serious health problems since the patient's childhood, yet did not do anything about these problems. The father suffered from chronic emphysema, yet he refused to cut down on his smoking. Similarly the father refused for years to consult a dentist, and when he finally did so, his condition was so poor that all of his teeth had to be removed. The patient characterized his father as extremely passive, joyless, unable to "stick up for his rights," and as someone who was "hopelessly stuck."

The patient said little about his mother at intake, except to note that she was a "kind" woman, an "excitable" woman who sometimes took tranquilizers, and a weak woman who complied with her husband's drab life-style. The patient made clear that he disliked the dull, joyless, extremely sedentary life that both of his parents led. "When they were in their 40s, they lived their lives as if they were in their 70s." They did very little as individuals or as a family. The father came home from his low-level job and sat around passively or slept. The patient referred to his father as "dead at night."

We inferred that the patient had developed the pathogenic belief that he was responsible for the unhappiness of both parents and, most manifestly, for the unhappiness of his father. Although he felt responsible for his father, the patient felt deeply frustrated by his inability to do anything useful for him. We also inferred that the patient's own initiative had been squelched in various ways—in part, by identification out of guilt with his passive parents; in part, by the discouraging failure of any action he took to actually change his parents' situation; and in part, by his perception that both parents were hurt by any initiative, independence, or happiness which the patient displayed.

What did we infer the patient wanted to do? We assumed he wanted to escape his parents and to stop worrying about them; have ambitions and initiative; overcome self-critical feelings; allow himself to feel pleasure, hope, and

enthusiasm; and ultimately, to have pleasurable sexual relations. He could not pursue these goals successfully because of an unconscious pathogenic belief that being active, lively, taking initiative, having sexual pleasure, and so forth would be hurtful to his parents.

We inferred also from the intake interview and from the first therapy interview how the patient would work to overcome his pathogenic beliefs, and thereby to make progress toward his goals. Broadly speaking, he could overcome these beliefs partly through testing whether the therapist shared them. He could do so by giving the therapist excessive responsibility for his suffering and unhappiness, as he had felt responsible for his parents' suffering and unhappiness. If the therapist did not feel excessively responsible for him, this would reduce, to some extent, the patient's own belief that he was responsible for his parents. He could also test his pathogenic beliefs by disparaging and discouraging the therapist's initiatives as he himself had been discouraged as a child. If the therapist was undaunted, this would also help to disconfirm the patient's conviction that he must give up his initiative because his parents discouraged it and did not seem to like it. The patient could also test the therapist to see if the therapist, like his parents, was unable to confront problems. Thus the patient might present a problem and then minimize it, with the (unconscious) hope that the therapist, unlike his parents, could face problems. Moreover, the patient might experiment with feeling some happiness or taking some initiative and then observe whether his initiative and happiness hurt or depressed the therapist.

We now report briefly on what actually did happen during this therapy. In fact, the patient's behavior corresponded very closely to the predictions described in this formulation. The patient actively tested the therapist's omnipotence throughout therapy: He tested whether the therapist had an irrational belief that he was magically responsible for the patient's happiness and well-being. The patient also tested whether the therapist would feel helpless and discouraged by the patient's doubts, criticisms, and lack of immediately progressive reactions to the therapist's interventions. For example, the patient frequently complained that the therapist was not doing enough for him and that he was not getting anywhere. He asserted that his life was going from bad to worse and that he wondered whether it was worth going on living. He repeatedly disregarded the therapist's interpretations or said that they were not helpful or that they were simply wrong. The therapist had to demonstrate in his behavior and in the implicit, if not explicit, content of his verbal interventions that he did not have an irrational, omnipotent sense of responsibility, and that he could persist undaunted in his interventions in spite of the patient's doubts, criticisms, and pessimism. As the therapist's behavior began to disconfirm the patient's belief in his own omnipotence (and the associated pathogenic beliefs to which we have alluded), the patient's behavior began to

change. He began to boast a little, to take a little initiative, and to have fun in a tentative but manifest way. In so doing, he was testing the therapist to see if the therapist would be threatened or hurt by his separateness and by his capacity to take initiative and to have fun; he was also testing to see if the therapist would attempt to discourage him as he felt his parents had. As the therapist passed *this test*—by not appearing hurt, saddened, or threatened by the patient's initiative—the patient showed further improvement.

When the patient was evaluated 1 year after therapy, the improvement that he had made was evident. He had started a relationship with a woman toward whom he felt affectionate, and he was able to have sexual intercourse with her. The clinical evaluator who interviewed Mike was impressed with his strong, positive feelings toward this woman, his hopefulness, and his aliveness. This was in sharp contrast to the initial (pretherapy) interview in which the patient complained of an inability to feel emotions or to be interested in anything.

Like the case of Myra, Mike's therapy illustrates the imprecision of the technical recommendations frequently advocated for brief psychotherapy. Mike's therapist was not active, did not keep him on a specific focus, was not particularly interpretive, and did not focus heavily on the transference to the therapist. What the therapist did follow closely was Mike's unconscious plan. In this case, and in others that we have started to study, the patient's plan and the patient's tests have required the therapist to be relatively inactive and thereby not to assume excessive responsibility for the patient's suffering and unhappiness. In this regard, the case of Mike underscores the importance of determining where the patient wants to go and adopting a stance that will help the patient get there.

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